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All Aboard the “Abortion Express”: Geographic Variability, Domestic Travel and the 1967 Abortion Act

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The Abortion Act, 1967, was a landmark piece of legislation which liberalized access to abortion in Britain and sparked a wider wave of global reform. Crucially, the Act placed abortion firmly under medical control, since two registered medical practitioners were required to certify that appropriate indications existed.² It can be contrasted with the ‘abortion on request’ system that many European countries have since chosen to adopt for at least the first trimester of pregnancy. As Sally Sheldon has argued, the “medicalization” of British abortion policy has been a decidedly mixed blessing for it has “depoliticised the extension of women’s access to abortion services” and “defused political conflict”, but it has also left women “dependent on the vagaries of medical discretion and goodwill”.³

The legislation succeeded where six previous bills had failed, yet this did not secure goodwill upon its passing. In fact, criticism of the Act and its operation began to build from the moment it came into effect on 27 April 1968, stimulating the government’s 1970 announcement that it would establish an official enquiry to review the Act’s operation, though not its wording or principles.⁴ A 15-member Committee on the Working of the Abortion Act was assembled, better known as the Lane Committee since it sat under the chairmanship of Justice Elizabeth Lane (1905-1988), the first female High Court judge in England. It began to take evidence in August 1971 – in both written and oral form – from a wide variety of private individuals and organizations from the fields of medicine, law, education, welfare and religion. This was to be the first and only thorough review of the working of the Abortion Act, and the comprehensive witness testimony collected provides a

unique opportunity to examine the perceived deficiencies of the Act when it was initially implemented.

This chapter will focus upon one of the most prominent strands of criticism presented to the Lane Committee: a profound geographic variability in British abortion provision, and the associated need for women to travel to another part of the country in order to access services.⁵ By the early 1970s, it had already become apparent that there were pronounced geographical variations in how the Act was being interpreted, and ironically so since the 1967 Abortion Act was the first piece of abortion-related legislation to cover Britain – Scotland, England and Wales – collectively. Using the witness testimony and final reports of the Lane Committee, in conjunction with a wider range of medical, governmental and newspaper archives, this chapter will map the “postcode lottery” of abortion provision in these early years of the Act’s operation, and – particularly through the work of the psychiatrist I. M. Ingram – explore the tensions which constrained access to abortion in certain parts of the country and propelled women elsewhere.

Scotland

Even before the 1967 Abortion Act came into effect, Scotland was noted for the geographic variability of its abortion provision. In Scotland, abortion constituted a common law offence without strictly defined limits. In the decades before 1967, the Scottish legal establishment considered abortion a matter of medical discretion, and advised that it was possible for a medical practitioner to terminate a pregnancy when acting in “good faith” in the interests of the health or welfare of his patient.⁶ In short, abortion was only a crime if “criminal intent” could be proved, doctors otherwise having freedom to practise in accordance with their clinical judgement. Yet, the oral testimony of retired Scottish medical practitioners suggests

that most Scottish doctors failed to exploit the flexibility of Scots law in this sphere because they were unaware of their legal rights.⁷ Neither the nuances of abortion law nor the differences between English and Scottish law were made clear to medical students,⁸ so that graduates generally believed that performing an abortion was a crime unless the woman's life was in imminent danger.

In only one area of Scotland do doctors appear to have taken full advantage of the potential flexibility of Scottish abortion law in the decades before the 1967 Act, and that was in Aberdeenshire in northeast Scotland, under the guidance of the chief gynecologist, Dugald Baird (1899-1986). Employed initially as a gynecology registrar at Glasgow Royal Infirmary, it was in that city, the largest and also the most Catholic in Scotland,⁹ that Baird witnessed the excessive childbearing, high maternal mortality, and highly restrictive access to fertility limitation that was to shape his future career. These factors, and most notably his frustration with the city's Catholic administration – which in one case caused him to remove a priest from the hospital by “[tak[ing] him by the back of the neck and march[ing] him down the stairs and chuck[ing] him out onto the street”¹⁰ – propelled him out of Glasgow. In 1936, he accepted an appointment to the Regius Chair of Midwifery at the University of Aberdeen, a city with a supportive medical and political infrastructure, and a “liberal” population in political and religious terms.¹¹

Conscious of the tenuous legal standing of abortion in Scotland, Baird sought the advice of Thomas Smith, Professor of Law at the University, for clarification on the issue. Smith reportedly explained that there was little likelihood of prosecution against doctors who terminated a pregnancy unless the authorities were convinced of “criminal intent”.¹² Armed with this assurance, Baird and his colleagues adopted an active “therapeutic abortion” policy under which they chose to recognise an increasing number of social as well as medical indications that might adversely affect a woman's health. When the young Liberal politician

David Steel put forward the bill that would become the 1967 Abortion Act, some questioned the involvement of a Scottish politician in the matter given the greater flexibility of Scots' abortion law. However, according to Steel, Baird made him aware that he was "the only person" who – thanks to his "considerable [professorial] status and the security which that brings" – felt able to take advantage of Scots common law to "follow his professional conscience".¹³ As such, Baird was invited to become a medical advisor to the Abortion Law Reform Association (ALRA), the most notable of the activist groups working to liberalise access to abortion, an appointment that he accepted with enthusiasm.¹⁴

Working for the "other side" was Baird's Glasgow-based equivalent. Ian Donald (1910-1987), an English obstetrician who in 1954 had accepted the Regius Chair of Midwifery at the University of Glasgow, was a founding member of the Society for the Protection of the Unborn Child (SPUC), the most organized activist group working in opposition to Steel's Bill. An active member of the Scottish Episcopal Church, Donald characterised most abortions as "legalised murder" performed for "flimsy reasons", and lamented: "I joined this profession to save life not to kill babies".¹⁵ Donald's campaigning was highly effective in combination with the medical technology that he had developed: obstetric ultrasound. At a time when ultrasound was not used routinely in the management of pregnancy, he employed these images and recordings of the fetus' beating heart as a powerful anti-abortion device, both at public rallies and in his own institution, the Queen Mother Maternity Hospital, in a deliberate attempt to deter women seeking an abortion.¹⁶

The divergence in opinion between Baird and Donald is reflected in their cities' abortion statistics. In the decade before 1966, Aberdeen had the highest abortion rate of any Scottish city, and Glasgow the lowest; according to the press, 1 pregnancy in 50 was terminated in Aberdeen compared to 1 in 3,750 in Glasgow.¹⁷ In the year the Act was implemented (1968), the rate ranged from 4.6 per 1,000 women in the Northern Hospital

Board Region (where Aberdeen was situated) to 1.6 per 1,000 women in the Western Hospital Board Region (where Glasgow was situated).¹⁸ This pronounced variation was to continue throughout and beyond the life of the Lane Committee: the abortion rate per 1,000 women aged 15-44 for the last quarter of 1974 was 12.6 in the Northern region, compared with 7.4 for Scotland as a whole.¹⁹ It should be noted that the vast majority of these abortions were performed under the National Health Service (hereafter NHS): almost 99 per cent in 1973.²⁰ Indeed, there was very little private medicine in general in Scotland.

So striking were the variations in these figures that a popular tabloid, the *Scottish Daily Record*, devoted a special “shock issue” to the subject. It reviewed abortion provision in the major Scottish cities, and deplored the fact that obtaining an NHS abortion was highly dependent on where you happened to live, despite its founding principle as a free and universal healthcare provider.²¹ Glasgow was said to have “diehard pro and anti-abortion forces ... battling it out in the various theatres of war”, while the Capital city of Edinburgh seemed to leave abortion “pretty much to the consciences of individual doctors”. In Dundee, it was estimated that more than 700 abortions were being carried out yearly, the highest rate per head of population in Scotland. As one of the city’s senior gynecologists observed: ‘It has reached the stage where we carry out abortions almost on request. Though we don’t shout it from the rooftops.’ Finally, Aberdeen was said to be ‘[s]till among the leaders’, although only women living in the hospitals’ catchment area were considered. As the newspaper concluded, the working of the Abortion Act was “a giant lottery and if your number [came] up you [could] thank lady luck for the privilege.”

Concerns over geographical variation in abortion provision were expressed similarly in witness testimony to the Lane Committee. The Scottish General Medical Services Committee claimed that facilities were “sporadic and unevenly distributed throughout the country” due to doctors’ individual attitudes.²² As the Scottish Association of Executive

Councils noted: “Variation in the application of the Act ... sometimes result[ed] in ‘shopping around’ to find a gynaecologist whose interpretation of the criteria [was] liberal and who [was] prepared to agree to termination of a pregnancy.”²³ Indeed, the Board of Management for Glasgow Royal Infirmary, along with several other medical organizations, lamented the fact that it was this very “shopping around” that was responsible for their gynecological waiting list having doubled in just one year; since abortions required to be carried out “at the earliest possible moment”, “normal acute and sub-acute” cases had to be “deferred for unreasonable periods”.²⁴ Ian Donald’s grip on Scotland’s largest city was obviously weakening, as various witnesses described “the anomalous situation of being able to refer a patient in one area [of Glasgow] to a hospital serving that area with the reasonable prospect that she will be judged suitable for termination of her pregnancy and at the same time having to advise a woman living in another area, whose grounds for termination are at least as strong, that it is pointless to refer her to the hospital serving her area.”²⁵

Due in large part – though not exclusively – to this geographical inequality, significant numbers of women normally resident in Scotland were reported to be obtaining abortions in England, and the vast majority in non-NHS premises. From 1972, about 7,500 abortions were carried out each year in Scotland, while as many as 1,000 women traveled south for an abortion.²⁶ As the Medical Secretary of the Glasgow Local Medical Committee lamented, “much against his inclination” a doctor in certain parts of Glasgow might feel obliged to advise a woman with an unwanted pregnancy to use “the private services operated in England”.²⁷ He deplored the fact “that one patient [could] have certain services provided free under the NHS” while another living nearby, and whose grounds for termination were at least as strong, would have “to be put to the expense of travelling to England and paying privately for the same service.” Doctors had reportedly complained to the Glasgow Local Medical Committee that they “felt it their duty to assist” such women “by making the

necessary arrangements for her to be seen at such a [private] clinic”.²⁸ Furthermore, as the Medical and Dental Defence Union of Scotland warned, the family doctor of any women who travelled for an abortion was unlikely to be notified, and it was “utterly wrong that her doctor should be kept in ignorance as he may very well be called in to deal with post-abortion complications”.²⁹

Birmingham, Liverpool and London appear to have been the most popular destinations for Scottish women seeking a private abortion, for reasons discussed below. Indeed, the Glasgow-Liverpool train was reportedly nicknamed “the Abortion Express” in recognition of this traffic south by women forced to pay for the operation because a free NHS abortion had been denied them. One particular “cut price” clinic in Liverpool dealt with 720 Scottish girls in 1972 alone.³⁰ As one west of Scotland doctor lamented:

The Act might as well not have been passed as far as my patients are concerned In all but a few specialised cases I have to send them south and they have to pay However you feel about abortions, this is not justice, not law, and not what the National Health Service is supposed to be about.³¹

To a much lesser extent, Edinburgh also witnessed attempts by Glaswegian women to access abortion services. As a growing number of women took the “abortion shuttle that stops at Edinburgh”, local doctors complained increasingly of the associated “crisis” of stretched hospital resources.³² As one consultant gynecologist protested, ‘I don’t think Edinburgh should be solving their problems.’ Anecdotal evidence suggests that Scottish women might also try their luck in Aberdeen, with the euphemistic claim that they were “going to see Uncle Dugald”.³³

It should be noted that the post-1970 statistics indicate that Scottish women who obtained an abortion in England were on average younger than the women who remained in Scotland, with a particular over-representation of women in their early 20s in the traveling

group. It is therefore possible that some women who left Scotland did so as a matter of personal preference, perhaps to safeguard their confidentiality, rather than through problems of local access *per se*. As the Lane Committee reported, the private sector enabled patients who could afford it “to have treatment in the privacy and with the amenities they desire.”³⁴ However, evidence also suggests that doctors in Scotland were more willing to terminate the pregnancies of respectable married women who already had a family than the younger generation with very different standards of sexual behavior than their parents and, more specifically, their doctors.³⁵ One Scottish study found that those recommended for an abortion had a mean age of 31 years, and those refused an abortion had a mean age of 24, young single women “provok[ing] the most moralistic response” from their doctors.³⁶ Indeed, in their evidence to the Lane Committee, the Royal College of Physicians of Edinburgh noted that some doctors opposed abortion for this group as it would remove “a natural barrier to promiscuity”.³⁷

A final relevant factor when analysing the significance of age is the fact that young women were more likely to be constrained by fear, parental disapproval, denial, or – for those living in the Highlands and Islands – practical difficulties in accessing a family doctor, and were thus more likely to request an abortion at a later stage of their pregnancy. As the fetus was approaching viability, and with a higher risk of complications, doctors may have felt greater reluctance to approve an abortion request.³⁸ For all of these reasons, it is important to note that, while the vast majority of abortions in Scotland were performed under the NHS, the private sector in England clearly served Scottish women, and continues to do so. This appears to have become the case in recent decades for women of all ages who seek an abortion for non-medical reasons in Scotland after 18-20 weeks’ gestation. Despite the fact that the official time limit in Britain is 24 weeks, these women tend to be denied an NHS abortion in

Scotland and forced to travel to England where they must pay their own costs up-front, often without knowledge that their local NHS Board should reimburse them retrospectively.³⁹

England and Wales

Prior to 1967, any attempt to procure an abortion in England and Wales, “whether she be or be not with Child”, was outlawed by the 1861 Offences Against the Person Act.⁴⁰ The crime was not the abortion itself but the doing of an act with intent to procure abortion, hence the woman did not actually have to be pregnant. This legislation was qualified by the 1929 Infant Life (Preservation) Act, which exempted those cases where abortion was deemed necessary to save the life of the mother;⁴¹ and a 1938 judicial ruling, *Rex v. Bourne*, which interpreted the 1929 Act as permitting abortion where “the probable consequences of the continuance of the pregnancy [were] to make the woman a physical or mental wreck”.⁴² Given the exceptional nature of the Bourne case – where a London obstetrician terminated the pregnancy of a 14-year-old girl who had been raped by a group of soldiers, then invited the law to prosecute him – most doctors remained deeply uncertain over the legalities of abortion, and were thus highly wary of involvement in that sphere. Nonetheless, as the ALRA campaigner Alice Jenkins’ provocatively titled *Law for the Rich* suggested, women from well-to-do families seemed able to find a doctor who would provide a safe abortion in a private facility,⁴³ while working-class women played “Russian roulette” with more affordable back-street abortionists or attempted to self-induce an abortion. Thus, as in Scotland, abortion provision was highly variable, though perhaps more for reasons of wealth than location.

When the Abortion Act came into force in April 1968, English critics quickly focused on a set of concerns that was rather distinct from those articulated in Scotland, since the relative dominance of the private sector in England tended to be portrayed across Britain as

“the cause of all the subsequent troubles in the south”.⁴⁴ Certainly, witness testimony to the Lane Committee supports this contention. In addition to the troublingly prominent and profiteering role of the private sector were the related concerns of British abortion services being advertised abroad, and access by foreign women to British abortion services.⁴⁵ It was also noted in the Committee’s final reports that comparisons between England and Scotland tended to be “affected by the non-resident component” in the former.⁴⁶ Nonetheless, geographical variation and the consequent need for women to travel, “forced to pay for abortions when they had legitimate medical grounds for termination of pregnancy under the Act”, was a leitmotif in those testifying across Britain.⁴⁷

A review of NHS abortion rates in the first year of the Act illustrates an already significant variation in provision. Per 1,000 females aged 15-44 years, the abortion rate ranged from 2.36 in North-West London and 2.04 in Newcastle to 0.85 in Birmingham and 0.71 in Liverpool. Wales sat sixth highest in the rankings, at 1.65 per 1,000 women. By 1971, on the eve of the Lane Committee’s establishment, positions had changed slightly, from South-East London (8.34), Newcastle (7.96) and North-West London (7.70) to Liverpool (4.16), Leeds (3.94) and – bottom of the league table for NHS provision – Birmingham (2.34). This was a striking rise in the number of women successfully seeking an abortion across all regions of England and Wales in a mere four years, though this differed fairly dramatically from an increase of 175 per cent (Birmingham) through to 511 per cent (Sheffield).⁴⁸ It is worth noting that, outside London, very few NHS abortions were performed outside the patient’s area of usual residence. That is, many hospitals were choosing to implement a residency requirement. Also worth noting is the percentage of these women who were sterilized after their abortion: from 15.7 per cent in North-West London to 40.2 per cent in both Birmingham and Liverpool.⁴⁹ Finally, in the NHS sector, it was found in a 1971 survey of general practitioners that a fifth or more family doctors working in

Birmingham, Liverpool and Sheffield declared a conscientious objection to abortion – as many as 32 per cent in Liverpool – compared to 5 per cent in South-East London and 4 per cent in East Anglia.⁵⁰

Private sector abortions were noted by the Lane Committee “to have taken place in large numbers in relatively few regions”, those being North-West London, South-West London and Birmingham.⁵¹ In 1968, 11 out of the 15 regional hospital boards for England and Wales notified that more than 90 per cent of their abortions were performed in NHS hospitals. Yet by 1971 this had fallen to 6 (Newcastle, Leeds, Sheffield, Oxford, Wales and Manchester), while in North-West London only 11 per cent of abortions were performed in an NHS facility.⁵² Birmingham saw quite a change in this regard: in 1968, 95.2 per cent of its abortions were performed in NHS facilities, but by 1971, this figure had dropped dramatically to 16.2 per cent.⁵³ Those regions which experienced a drop in the rate of NHS abortions tended to note “a substantial and rising” proportion of private operations in other parts of England,⁵⁴ as well as the establishment of other “approved” (that is, private) clinics in their regions, most notably those opened by the Birmingham (renamed British) Pregnancy Advisory Service (hereafter bpas) in Birmingham (1968) and Liverpool (1970). By 1971, the media was reporting that, of the 126,000 abortions performed in England and Wales, almost 60 per cent were carried out in the private sector: 40 per cent by profit-making enterprises, and 20 per cent by non-profit-making-charities, most notably bpas.⁵⁵

While they obviously lay at opposite ends of the spectrum for abortion provision in the immediate post-1967 period, Aberdeen, Glasgow and Birmingham shared an interesting connection in personnel terms. Once again, the senior gynecologist was exerting considerable influence on NHS abortion provision in Birmingham. Professor Hugh McLaren (1913-1986) was a leading medical opponent of abortion who joined Ian Donald as a founding member of SPUC, yet anecdotally it has been suggested that he had previously been Dugald Baird’s first

registrar in Aberdeen. Baird had famously influenced many of his junior staff while they worked under him, men who went on to fill a variety of senior positions across and beyond Britain, spreading Baird's philosophy to a notable extent. These included Ian MacGillivray, Baird's successor in Aberdeen, Alexander Turnbull, Professor of Obstetrics and Gynaecology at the Welsh National School of Medicine in Cardiff, and Malcolm Macnaughton, Senior Lecturer at the University of St Andrews and later President of the Royal College of Obstetricians and Gynaecologists. Such was their loyalty to him that a dozen of them – labelled the “twelve disciples” by the media – banded together to publicly voice their support for Baird's “liberal” policy even before the 1967 Act came into operation, and with a proposal to operate a similar policy in their own practice.⁵⁶ McLaren appears to have reacted rather differently to his time with Baird, and prevented the doctors working under him from performing an abortion in all but a fraction of cases.⁵⁷

Many English women living in cities like Birmingham were forced to travel outside their area of residence in search of an abortion. In 1968, 29.1 per cent of women resident in England and Wales obtained an abortion outside their home region.⁵⁸ Again, figures differed significantly across the country. Thus, 96.9 per cent of Newcastle residents – the highest proportion in England – obtained an abortion locally; at the other end of the table, the equivalent figures for Birmingham and South-West London were 57.9 and 31 per cent respectively. By 1971, while Newcastle remained at the top of the table (92.6 per cent), Birmingham had risen to second place (jointly with East Anglia), in both of which 83.8 per cent of residents obtained their abortion locally. Bpas provision had clearly made a significant impact in a short space of time. At the other end of the scale, 49.9 per cent of Leeds residents obtained their abortion in another region, and 69.5 per cent for South-West London. In their oral evidence to the Lane Committee, bpas staff suggested that, while Professor McLaren – “the head of all this side of the work in our teaching hospital” – had

declared “he would not sit in the same bus as the people who support” bpas, “a good many of the local doctors who might otherwise be under pressure” were “quite pleased to see that [bpas was] relieving them of this particular responsibility.”⁵⁹ When asked whether they saw bpas as “a permanent structure” or “something which in all conscience the health service should aim ultimately to replace”, François Lafitte, professor of social policy and administration at the University of Birmingham and chair of bpas (1968-88), noted their initial wish to exist purely as a “temporary voluntary group working in Birmingham alone”, but that while they would “rather not be in business”, staff had begun to accept “that we shall have to continue at any rate for some years, and that the scale of our work is growing and reaching the point when we have to think about pension schemes for our employees”.⁶⁰

Bpas benefitted many British women living in such “restrictive” areas as Birmingham because, unlike the NHS, it did not limit its services to those living nearby. In her oral evidence to the Lane Committee, one gynecologist complained that catchment areas were set by NHS hospitals for only a few select services, including abortion, whereas those who sought a chest operation or even plastic surgery could “go anywhere else for a preferred surgeon”.⁶¹ Similarly, a doctor based in London condemned his NHS colleagues who had introduced catchment areas only for their abortion services, which constituted “a selective discrimination in medical matters against human dignity” since these patients fulfilled the Act’s clinical requirements “as strictly interpreted”.⁶² As he concluded, “the Abortion Act works fully and successfully for the socially privileged but help for the working woman without means is very scarce and many unnecessary obstacles are put in her way.” Indeed, class was not the only variable to take into consideration. As the lengthy written submission from the Royal College of Obstetricians and Gynaecologists explained, the private sector recorded a much higher proportion of single women than the NHS; 69 per cent of the single women who received an abortion in 1968 had to, or chose to, pay for a private abortion.⁶³

Media exposés lambasted the “opportunity given to private entrepreneurs” in the “abortion market” during these early years, and speculated about their level of profiteering.⁶⁴ BPAS charged between £51 and £65 per abortion and still managed to cover the cost of a free abortion for women who could not afford to pay. With English women charged between £100 and £120 on average for an abortion, private entrepreneurs might make a profit of £50 per resident woman (and up to £120 per foreign woman) from those able to afford these services.⁶⁵

“Abortion Games”

The complex dynamics of doctors engaged in the abortion decision-making process in the early years of the 1967 Act, and resulting need for women to travel, were neatly summed up by I. M. Ingram, a psychiatrist based at the Southern General Hospital, Glasgow. His controversial 1971 article, “Abortion Games: An Inquiry into the Working of the Act”, published in *The Lancet* medical journal, arguably constituted one of the most damning medical indictments of the legislation.⁶⁶ Ingram was here inspired by the Californian psychiatrist Eric Berne’s “transactional game analysis”, which defined “game” not as a “frivolous” activity but as “an ongoing series of superficially plausible transactions with a concealed or dishonest motivation”.⁶⁷ Ingram argued that the Abortion Act had “created an arena for the development and multiplication of a variety of games”, the concealed function of which was to “abolish or minimise personal responsibility for decisions made for or against termination.”⁶⁸ The psychiatrist was quick to point to the source of the conflict: the “compromise wording” of “a meaningless Act”, which left “the scrupulous and cynical doctor alike ... obliged to give opinions on matters which he considers to be non-medical,” since the pregnant woman was “not ill in a strict medical or psychiatric sense”, and which

asked the doctor “to take life when his natural feelings and training predispose him to conserve it.”

The family doctor, acted as the gate-keeper to abortion services, and had a variety of options open to him in order to devolve responsibility. The obvious strategies entailed trying to discourage the pregnant woman from seeking an abortion or refusing to refer her anywhere. Alternatively, he could obligingly refer her to a local hospital but, rather than make his own recommendation for or against the procedure, simply write a neutral letter committing himself to no decision and thus evading responsibility for whatever would follow. Ingram referred to this game as “Pontius Pilate.” Alternatively, the family doctor could covertly disapprove of an abortion but evade a confrontation with the pregnant woman by apparently agreeing to her request and referring her to a specialist known to be antagonistic, the game of “Bounced Cheque.”

The Glasgow-based obstetrician Ian Donald illustrated the “streaming phenomenon” that lay behind this last strategy, whereby family doctors “quickly came to know which units would readily carry out abortions and which were ‘likely to prove sticky’.”⁶⁹ As Donald noted, due to the “strict line” which he took in his own unit, most abortion requests came to him from doctors “seeking support in their view that the request for termination of pregnancy should be refused.” Thus, the family doctor could effectively harness his knowledge of local gynecologists’ attitudes towards abortion, enabling him to refer the woman to that consultant whose decision coincided most neatly with his own views, whether sympathetic or hostile. Since, under the NHS, the patient first had to consult a family doctor for referral to the specialist, this procedure afforded that practitioner a great deal of discretion in how the Abortion Act was interpreted.

The gynecologist had, according to Ingram, a greater and more complex range of “games” open to him. For those in positions of authority, “Big White Chief” was a

particularly popular and effective game, played by a professor or head of department who imposed on his staff an extreme policy for or against termination. Ostensibly, his justification was “logical and medical”, although “covert ethical, religious, and personal motives” could often be inferred.⁷⁰ This extreme view would prejudge all individual cases, thus simplifying decision-making in this area, and would be enforced in an authoritarian way with all the prestige that Big White Chief commanded, in some cases spreading to whole cities and regions. A dominating senior gynecologist, such as Baird in Aberdeen, Donald in Glasgow or McLaren in Birmingham, could exert significant influence on his “Little Indian” junior staff, be it to encourage very restrictive or liberal access to abortion.

This game had far-reaching effects. Since the general practitioner would know the consultant’s views and refer or divert patients accordingly, within a short time “Big White Chief” would see only those patients he wanted to see, becoming a self-fulfilling prophet. His neighbouring colleagues, who were likely to see many more patients as a result, might play a corresponding defensive game of “Catchment Area”. Thus in 1973, Dugald Baird’s successor, Professor Ian MacGillivray, had publicly to state that only women living in the hospital’s catchment area would be considered for a termination, and that “a woman who [could not] get an abortion elsewhere in Scotland [would not] get one in Aberdeen”.⁷¹ Similarly, as a result of Donald’s restrictive influence on abortion provision in certain areas of Glasgow, those liberal gynecologists now operating in the City – most notably Professor Malcolm Macnaughton at the Glasgow Royal Infirmary – came under increasing pressure to refuse patients who lived outside the hospital catchment area. And such a system would be particularly problematic in smaller or more remote areas, as Baird lamented, where there might be great difficulty in obtaining an alternative opinion.⁷²

Another game said to be popular among gynecologists was “Plumber”. Here, the doctor would claim to be merely “a technician, an honest, simple craftsman whose abilities

[were] bounded by the female pelvis,” and who would maintain that psychiatric and social factors did not fall within his competence, thus devolving responsibility to the family doctor, social worker, or psychiatrist.⁷³ The obverse of this game was “Amateur Psychiatrist” or “Young Dr. Kildare”, where the gynecologist “turn[ed] his hand enthusiastically to psycho-social diagnosis and treatment”, a task for which he was “ill-suited by training and temperament”. Other, more obvious, gynecologist strategies were noted to include “Waiting-list”, in which the patient had to wait months for an appointment, perhaps until it was too late, and “Sterilization”, where the pregnant woman was provided with the desired abortion only on the condition that she simultaneously allow herself to be sterilised. Ingram mentioned an additional game, “Cash Before Delivery”, but considered this more of “a business game ... than a medical one”, and one “largely confined to the Home Counties”.⁷⁴

Finally, Ingram did not absolve his own specialty from blame, and in fact claimed that psychiatrists – with their “specialist training in game theory and practice” – had demonstrated “more sophistication – or sophistry – in their choice of gambits”.⁷⁵ The best documented was named “Sim’s Position”, where the doctor adopted the stance that there were no psychiatric indications for abortion, based on evidence that the major psychoses were not worsened by pregnancy and that suicide was rare during pregnancy. The main assumption here – and it was “a big one” according to Ingram – was that the reference to mental health in the Act meant the absence of psychotic illness, and no more. The psychiatrist playing this game would thus maintain that the vast majority of women requesting an abortion did not fall within his province and, like Big White Chief, he would be unlikely to be troubled much on this subject once his views became widely known. While “Sim’s position” is a type of gynecology examination position, the game itself was named after the Birmingham psychiatrist Myre Sim’s refusal to bow to pressure brought to bear on the psychiatrist to

recommend a termination. He reportedly felt it more appropriate to “nurse the patient through her unstable phase.”⁷⁶

A second psychiatric game involved an opposite reading of the Act’s wording. The doctor chose to interpret mental health in the widest possible sense, and maintained that, if a woman was “forced to bear an unwanted child”, then her mental health “must automatically suffer”.⁷⁷ The wording of the legislation could effectively be interpreted as justifying abortion on request. The Act permitted an abortion where “the continuance of the pregnancy would involve risk ... greater than if the pregnancy were terminated”.⁷⁸ As the Royal College of Psychiatrists noted in the year following Ingram’s article, this justified a doctor to recommend an abortion in every case presented to him, since the danger of death as a consequence of legal abortion (21 per 100,000 cases in the first year of the Act) was lower than that of dying in childbirth (24 per 100,000 cases).⁷⁹ Ironically, this clause had been added in the final stages of debate in the House of Lords by opponents of abortion, who labored under the false assumption that early termination was in fact more dangerous than a full-term pregnancy.⁸⁰ Ingram named this game “Woman’s Lib.”, since the object was “to place the ball of decision firmly in the woman’s court, in part removing the decision from the doctor”.⁸¹

The final “player” was the pregnant woman herself, who might “play games spontaneously or in response to medical games”.⁸² She was often obliged to play “Obstacle Race”, where each of the games mentioned above constituted a potential obstacle to be overcome in her search for a legal abortion. She required “luck and determination ... to succeed”, and as Ingram warned, “honesty may not be rewarded”. The woman prepared to play “Psychiatric Case”, producing “the symptoms that the doctor seeks” to feel he can justify an abortion, was likely to be more successful than the “intelligent woman” who made her decision “rationally and calmly”. Another popular game, “Class Warfare”, referred to the

evidence that those from a higher social class were more likely to be successful in their request for an abortion. Middle-class patients were “usually more knowledgeable about the law” and “better able to put their case convincingly”, while doctors tended to sympathise more readily with girls “who might easily be their own daughters”. Thus, as Dugald Baird and his Aberdeen colleagues argued, doctors tended to see abortion as “a second chance” for the better-educated girl who was “anxious that [her] future should not be imperilled by one mistake.”⁸³ Thus the poorer patient suffered on two counts: she was both less likely to elicit sympathy in her family doctor, and less likely to be able to afford the travel, accommodation and private abortion if NHS provision was denied her.

Conclusion

Ingram’s *Lancet* article brought into sharp relief the inherent, and deeply damaging, ambiguities of the 1967 Abortion Act, and the resulting inconsistencies in decision-making across Britain. Women with an unwanted pregnancy who sought a termination after 1967 were not “ill” in any medical or psychiatric sense, yet were compelled to obtain permission from two registered medical practitioners, in part since doctors were the only people considered technically qualified to carry out the operation at a time when abortion was largely a surgical procedure. Doctors were arguably not qualified to lead – or even participate in – the decision-making process, though some were more enthusiastic or transparent than others in taking on this duty, and in influencing those around them to adopt a similar approach. Their ability to interpret the legislation so variably goes a long way in explaining the pronounced geographical disparities in British abortion provision, and the consequent need for many women to seek – and often finance – an abortion away from home. It also shines a slightly ironic light on the many foreign women – discussed in this volume by Christabelle Sethna – who sought an abortion in Britain, hardly a permissive haven for

resident women. British women who had to travel in search of, and find the money to pay, a private abortion provider appeared to experience little or no advantage in being a “resident” whose taxes funded the NHS.

And this was all to remain the case. The Lane Committee completed its investigations in 1974 with the publication of a three-volume report which suggested a variety of administrative measures to tighten the regulations and thereby improve the Act’s effectiveness. However, unexpectedly – given the scathing criticisms expressed by witnesses of the “considerable” problems identified – the report concluded by noting that the committee members were “unanimous in supporting the Act and its provisions”.⁸⁴ It recommended that “the wording of the Act laying down the criteria for abortion be left unamended”, that “doctors should continue to make the decision as to abortion”, and that “abortion work should not be restricted to the N.H.S.” but “should continue to be performed in the private sector without statutory restriction upon the qualifications of registered medical practitioners undertaking the operations, and without statutory control of fees”.⁸⁵ Thus the underlying conditions that created a market for abortion travel would remain in place.

Only recently, as the 1967 Abortion Act approached its 50th anniversary, has momentum built palpably for both the decriminalization and, to a more limited extent, demedicalization of abortion in Britain. The political architect of the Act, David Steel, has advocated decriminalization on the basis that British women are “miles behind our European neighbours who allow all women to access abortions on request”.⁸⁶ The three most relevant medical bodies – the Royal College of Midwives, British Medical Association, and Royal College of Obstetricians and Gynaecologists – one by one voted in support for abortion to be regulated “in line with other medical procedures, rather than criminal sanctions”.⁸⁷ Such statements have been cautiously welcomed by those who recognise remaining difficulties in women’s ability to access adequate abortion care, and the emotional and financial cost of

travel to obtain provision away from home, and as the increasing accessibility of abortifacients without the legal approval of medical gatekeepers – in particular, abortion pills sold online⁸⁸ – makes the prosecution of women with an unwanted pregnancy ever more likely. The same audience has welcomed the Scottish government’s October 2017 decision to allow women residing in Scotland to take the abortion pill “misoprostol” at home, albeit only when deemed “clinically appropriate”, thus allowing women “to be in control of their treatment and as comfortable as possible during this procedure”.⁸⁹ While women will still need to attend a medical facility to take the first pill, by obtaining the second at the same time this new judgement now removes the requirement for a return trip, and – as Jillian Merchant, the vice-chair of campaign group Abortion Rights UK, argues – allows women to escape the “horrendous experience of abortions commencing on public transport due to outdated legislation, which takes no account of medical advances or the reality of women’s lives”.⁹⁰

Endnotes

¹ The authors wish to thank the Arts and Humanities Research Council for their support of our research project, “The Abortion Act (1967): A Biography”, AH/N00213X/1.

² Full details of the Act can be found at Public General Statutes, Elizabeth II, CH. 87.

³ Sally Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto Press, 1997), 168.

⁴ National Records of Scotland (hereafter NRS), HH61/1315, draft memorandum by the Secretary of State for Social Services, 1970.

⁵ For a more complete overview of the Lane Committee’s proceedings, see Ashley Wivel, ‘Abortion Policy and Politics on the Lane Committee of Enquiry, 1971-1974’, *Social History of Medicine* 11 (1998): 109-35; Roger Davidson and Gayle Davis, *The Sexual State: Sexuality and Scottish Governance, 1950-80* (Edinburgh: Edinburgh University Press, 2012), 110-16.

⁶ NRS, HH41/1146, Briefing Notes on Abortion Bill, 2 February 1954.

⁷ Interviews by Gayle Davis with retired general practitioners, gynecologists and psychiatrists, April 2003-April 2004.

⁸ Indeed, textbooks such as John Glaister’s *Medical Jurisprudence and Toxicology*, the “medico-legal bible” for generations of doctors in Scotland, failed to differentiate between abortion law in Scotland and England.

⁹ N. A. Todd, “Psychiatric Experience of the Abortion Act (1967)”, *British Journal of Psychiatry*, 119 (1971), 491. Todd estimated that 30% of Glasgow’s population was Roman Catholic, compared with 17% for Scotland as a whole and 8% for England and Wales.

¹⁰ University of Aberdeen Special Collections, MS3620/21/1-2, Interview by Elizabeth Olson with Sir Dugald Baird, 3 April 1985.

¹¹ Roger Davidson and Gayle Davis, *The Sexual State: Sexuality and Scottish Governance, 1950-80* (Edinburgh: Edinburgh University Press, 2012), 100-1.

¹² Gopika Bhatia, "Social Obstetrics, Maternal Health Care Policies and Reproductive Rights: The Role of Dugald Baird in Great Britain, 1937-65", M.Phil. thesis (University of Oxford, 1996), 59.

¹³ *Observer*, 6 February 1966; *Observer*, 30 January 1966; Michael Kandiah and Gillian Staerck (eds), *The Abortion Act, 1967: Institute of Contemporary British History Witness Seminar* (London: Institute of Historical Research, 2002), 47.

¹⁴ Barbara Brookes, *Abortion in England, 1900-1967* (London: Croom Helm, 1988), 94-8; Stephen Brooke, "The Sphere of Sexual Politics: The Abortion Law Reform Association, 1930s to 1960s", in Nick Crowson, Matthew Hilton and James McKay, *NGOs in Contemporary Britain: Non-State Actors in Society and Politics since 1945* (Basingstoke: Palgrave Macmillan, 2009): 77-94.

¹⁵ *Scottish Daily Record*, 16 May 1973.

¹⁶ Wellcome Library (hereafter WL), SA/ALR/H.58, Note on a Public Abortion Meeting, Manchester, 6 December 1966; Malcolm Nicolson and John Fleming, *Imaging and Imagining the Fetus: The Development of Obstetric Ultrasound* (Baltimore: Johns Hopkins University Press, 2013).

¹⁷ *The Scotsman*, 23 December 1966.

¹⁸ *Report of the Committee on the Working of the Abortion Act, Volume 2: Statistical Volume, Cmnd. 5579* (London: Her Majesty's Stationery Office, 1974): 144.

¹⁹ Barbara Thompson, 'Problems of Abortion in Britain – Aberdeen, a Case Study', *Population Studies* 31 (1977), 153.

²⁰ NRS, HH101/2877, Note by SHHD, 4 February 1975.

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- ²¹ *Scottish Daily Record*, 16 May 1973; Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002).
- ²² NRS, HH102/1232, Notes of Meeting between SHHD and Representatives of the Scottish General Medical Services Committee, 24 September 1974.
- ²³ WL, SA/ALR/C.27, Proceedings of the Lane Committee (hereafter PLC), Submission of A. W. Smith, Scottish Association of Executive Councils, 20 December 1971.
- ²⁴ WL, SA/ALR/C.35, PLC, Submission of Board of Management for Glasgow Royal Infirmary and Associated Hospitals, December 1971; SA/ALR/C.41, PLC, Submission of Lothian and Peebles Executive Council, Edinburgh, 2 November 1971.
- ²⁵ WL, SA/ALR/C.68, PLC, Submission of William Fulton, Medical Secretary, Glasgow Local Medical Committee, 9 March 1973.
- ²⁶ Hilary Homans (ed.), *The Sexual Politics of Reproduction* (Aldershot: Gower, 1985), 84-5.
- ²⁷ WL, SA/ALR/C.68, PLC, Submission of William Fulton, Medical Secretary, Glasgow Local Medical Committee, 9 March 1973.
- ²⁸ Ibid.
- ²⁹ WL, SA/ALR/C.35, PLC, Submission of The Medical and Dental Defence Union of Scotland, 28 December 1971.
- ³⁰ *Scottish Daily Record*, 16 May 1973.
- ³¹ Ibid.
- ³² *Sunday Standard*, 24 May 1981.
- ³³ Interview by Gayle Davis with practicing general practitioner, 24 February 2004.
- ³⁴ *Report of the Committee on the Working of the Abortion Act, Volume 1: Report, Cmnd. 5579* (London: Her Majesty's Stationery Office, 1974), 183.
- ³⁵ E. M. Briggs and A. E. Mack, "Termination of Pregnancy in the Unmarried", *Scottish Medical Journal* 17 (1972): 398-400.

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- ³⁶ E. Hamill and I. M. Ingram, "Psychiatric and Social Factors in the Abortion Decision", *British Medical Journal* 1 (1974), 231.
- ³⁷ WL, SA/ALR/C.25, PLC, Submission of Royal College of Physicians, Edinburgh, 1972.
- ³⁸ Todd, "Psychiatric Experience of the Abortion Act", 492.
- ³⁹ "Women Travelling to England for Abortions", BBC News, 13 June 2017, <http://www.bbc.co.uk/news/uk-scotland-scotland-politics-40257828>, last accessed 8 November 2017; Carrie Purcell et al., "Access to and Experience of Later Abortion: Accounts from Women in Scotland", *Perspectives on Sexual and Reproductive Health* 46:2 (2014): 101-108.
- ⁴⁰ Public General Statutes, 24 & 25 Vict., CH. 100.
- ⁴¹ Public General Statutes, 19 & 20 Geo. V., CH. 34.
- ⁴² For further details of this case and its wider context, see John Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (Cambridge: Cambridge University Press, 1988), 49-59.
- ⁴³ Alice Jenkins, *Law for the Rich: A Plea for the Reform of the Abortion Law* (London, Victor Gollancz, 1960). For a fuller discussion of the perceived relationship between class and abortion in Britain, see Brooke, "The Sphere of Sexual Politics."
- ⁴⁴ NRS, HH61/1315, R. M. Bell to J. Walker, 31 March 1970.
- ⁴⁵ Ashley Wivel, "Abortion Policy and Politics on the Lane Committee of Enquiry, 1971-1974", *Social History of Medicine* 11 (1998): 109-35.
- ⁴⁶ *Report of the Committee on the Working of the Abortion Act, Volume 2*, 45.
- ⁴⁷ *Report of the Committee on the Working of the Abortion Act, Volume 1*, 183.
- ⁴⁸ *Report of the Committee on the Working of the Abortion Act, Volume 2*, 109.
- ⁴⁹ *Ibid.*, 147-9.
- ⁵⁰ *Ibid.*, 111.

⁵¹ *Ibid.*, 135.

⁵² *Ibid.*, 138.

⁵³ *Ibid.*, 139.

⁵⁴ *Ibid.*, 140.

⁵⁵ “Economics of the Abortion Market”, *Daily Telegraph*, 22 March 1972.

⁵⁶ *The Scotsman*, 14 December 1966.

⁵⁷ Alex Mold, *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester: Manchester University Press, 2015).

⁵⁸ *Report of the Committee on the Working of the Abortion Act, Volume 2*, 138.

⁵⁹ WL, SA/ALR/C.81, PLC, Submission of Birmingham Pregnancy Advisory Service, 28 June 1972.

⁶⁰ WL, SA/ALR/C.81, PLC, Submission of Birmingham Pregnancy Advisory Service, 28 June 1972.

⁶¹ WL, SA/ALR/C.75, PLC, Submission of Miss Dorothea Kerslake, FRCOG, 26 January 1972.

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⁶³ Royal College of Obstetricians and Gynaecologists, A16-6, Submission of Royal College of Obstetricians and Gynaecologists to the Lane Committee, undated (c.1971-2).

⁶⁴ “Economics of the Abortion Market”, *Daily Telegraph*, 22 March 1972.

⁶⁵ *Ibid.*

⁶⁶ I. M. Ingram, “Abortion Games: An Inquiry into the Working of the Act”, *Lancet* 2 (1971), 969-70.

⁶⁷ See Eric Berne, *Games People Play: The Psychology of Human Relationships* (London: Grove Press, 1964), 44-45.

⁶⁸ Ingram, “Abortion Games”, 969.

⁶⁹ Ian Donald, “Naught for your Comfort”, *Journal of the Irish Medical Association* 65 (1972), 286

⁷⁰ Ingram, “Abortion Games”, 969.

⁷¹ *Scottish Daily Record*, 16 May 1973.

⁷² Dugald Baird, “The Abortion Act 1967: The Advantages and Disadvantages,” *Royal Society of Health Journal* 90 (1970), 294.

⁷³ Ingram, “Abortion Games,” 969.

⁷⁴ *Ibid.*, 970.

⁷⁵ *Ibid.*

⁷⁶ Myre Sim, “Abortion and the Psychiatrist”, *British Medical Journal* 2 (1963), 148.

⁷⁷ Ingram, “Abortion Games”, 970.

⁷⁸ Public General Statutes, Elizabeth II, CH. 87.

⁷⁹ “The Royal College of Psychiatrists’ Memorandum on the Abortion Act in Practice”, *British Journal of Psychiatry* 120 (1972), 449.

⁸⁰ Kandiah and Staerck, *The Abortion Act, 1967*, 50.

⁸¹ Ingram, “Abortion Games”, 970.

⁸² *Ibid.*

⁸³ Baird, “The Abortion Act 1967”, 293; Jean Aitken-Swan, *Fertility Control and the Medical Profession* (London: Croom Helm, 1977), 11.

⁸⁴ *Report of the Committee on the Working of the Abortion Act, Volume I*, 184.

⁸⁵ *Ibid.*, 186-8.

⁸⁶ David Steel, ‘I Introduced the Abortion Act 50 Years Ago this Week. This is Why it Now Needs Extending’, *Independent*, 26 October 2017.

⁸⁷ See, for example, Denis Campbell, ‘Abortion Should Not be a Crime, Say Britain’s Childbirth Doctors’, *The Guardian*, 22 September 2017.

⁸⁸ See, for example, ‘British Women are Ordering Abortion Pills Online due to Difficulty Accessing Clinics’, *The Debrief*, <http://www.thedebrief.co.uk>, last accessed 8 November 2017.

⁸⁹ Libby Brooks, ‘Women in Scotland will be Allowed to Take Abortion Pill at Home’, *The Guardian*, 26 October 2017.

⁹⁰ Ibid.